		FOR BHF USE					

LL1

2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026955

Facility Name: Washington Christian Village

Address: 1110 Newcastle Road (Number) Washington (City) 61571 (Zip Code)

County: Tazwell

Telephone Number: 309-444-3161 **Fax #** ( )

HFS ID Number: 37-0841562006

Date of Initial License for Current Owners: 04/01/1982

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501c3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: William E. Castor **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2004 to June 30, 2005 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Richard A. Walbert
(Title) Vice President of Finance

Paid Preparer
(Signed) (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	20,166	6,609	3,881	30,656	8
9	SNF/PED					9
10	ICF	9,640	1,891		11,531	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,806	8,500	3,881	42,187	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.74%

D. How many bed-hold days during this year were paid by the Department?
372 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 04/01/1982

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 04/01/1982 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 122 and days of care provided 3,881

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2005 Fiscal Year: 06/30/2005

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Washington Christian Village # 0026955 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	209,069	25,030	11,770	245,869		245,869		245,869			1
2	Food Purchase		234,086		234,086		234,086	(3,125)	230,961			2
3	Housekeeping	172,613	26,623		199,236		199,236		199,236			3
4	Laundry											4
5	Heat and Other Utilities			117,279	117,279		117,279	11,905	129,184			5
6	Maintenance	70,850	21,187	28,982	121,019		121,019	10,139	131,158			6
7	Other (specify):*											7
8	**TOTAL General Services**	452,532	306,926	158,031	917,489		917,489	18,919	936,408			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	2,109,321	278,368	10,839	2,398,528		2,398,528	(4,088)	2,394,440			10
10a	Therapy			286,871	286,871		286,871		286,871			10a
11	Activities	37,613			37,613		37,613	(51)	37,562			11
12	Social Services	110,722	4,417	3,480	118,619		118,619		118,619			12
13	CNA Training											13
14	Program Transportation			6,603	6,603		6,603	(3,926)	2,677			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,257,656	282,785	314,993	2,855,434		2,855,434	(8,065)	2,847,369			16
	C. General Administration											
17	Administrative	89,912	1,326	289,052	380,290		380,290	(215,635)	164,655			17
18	Directors Fees											18
19	Professional Services			32,719	32,719		32,719	11,419	44,138			19
20	Dues, Fees, Subscriptions & Promotions			41,172	41,172		41,172	(7,142)	34,030			20
21	Clerical & General Office Expenses	119,131	7,437	109,383	235,951		235,951	11,610	247,561			21
22	Employee Benefits & Payroll Taxes			533,638	533,638		533,638	32,465	566,103			22
23	Inservice Training & Education											23
24	Travel and Seminar			17,562	17,562		17,562	6,671	24,233			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			99,816	99,816		99,816	990	100,806			26
27	Other (specify):*											27
28	**TOTAL General Administration**	209,043	8,763	1,123,342	1,341,148		1,341,148	(159,622)	1,181,526			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,919,231	598,474	1,596,366	5,114,071		5,114,071	(148,768)	4,965,303			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Washington Christian Village #0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			151,145	151,145		151,145	20,183	171,328			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			356,843	356,843		356,843	(2,147)	354,696			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Deferred Bond Costs			1,167	1,167		1,167		1,167			36
37	**TOTAL Ownership**			509,155	509,155		509,155	18,036	527,191			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			16,122	16,122		16,122		16,122			39
40	Barber and Beauty Shops	22,377	1,011		23,388		23,388		23,388			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			66,795	66,795		66,795		66,795			42
43	Other (specify):* Apt/Cong			131,659	131,659		131,659	(13,831)	117,828			43
44	**TOTAL Special Cost Centers**	22,377	1,011	214,576	237,964		237,964	(13,831)	224,133			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,941,608	599,485	2,320,097	5,861,190		5,861,190	(144,563)	5,716,627			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,261)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(5,310)	32		10
11	Discounts, Allowances, Rebates & Refunds	950	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(13,831)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(46,672)	21		24
25	Fund Raising, Advertising and Promotional	(7,142)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attached	(36,806)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (111,072)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(33,491)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (33,491)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (144,563)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Washington Christian Village

ID# 0026955

Report Period Beginning: July 1, 2004

Ending: June 30, 2005

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous	$ (2,459)	17	1
2	Vending	(864)	2	2
3	Activity	(51)	11	3
4	Exempt Interest Income - Endowment	2,772	32	4
5	Marketing	(28,484)	21	5
6	Transportation	(3,926)	14	6
7	Loss on Disposal	294	21	7
8	Related Pharmacy Profit	(4,088)	10	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(36,806)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Washington Christian Village **#** 0026955 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,125)	0	0	0	0	0	0	0	0	0	0	(3,125)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	11,905	0	0	0	0	0	0	0	0	0	11,905	5
6	Maintenance	0	10,139	0	0	0	0	0	0	0	0	0	10,139	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,125)	22,044	0	0	0	0	0	0	0	0	0	18,919	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,088)	0	0	0	0	0	0	0	0	0	0	(4,088)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(51)	0	0	0	0	0	0	0	0	0	0	(51)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(3,926)	0	0	0	0	0	0	0	0	0	0	(3,926)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(8,065)	0	0	0	0	0	0	0	0	0	0	(8,065)	16
	C. General Administration													
17	Administrative	(2,459)	(213,176)	0	0	0	0	0	0	0	0	0	(215,635)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	11,419	0	0	0	0	0	0	0	0	0	11,419	19
20	Fees, Subscriptions & Promotions	(7,142)	0	0	0	0	0	0	0	0	0	0	(7,142)	20
21	Clerical & General Office Expenses	(73,912)	85,522	0	0	0	0	0	0	0	0	0	11,610	21
22	Employee Benefits & Payroll Taxes	0	32,465	0	0	0	0	0	0	0	0	0	32,465	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,671	0	0	0	0	0	0	0	0	0	6,671	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	990	0	0	0	0	0	0	0	0	0	990	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(83,513)	(76,109)	0	0	0	0	0	0	0	0	0	(159,622)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(94,703)	(54,065)	0	0	0	0	0	0	0	0	0	(148,768)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Washington Christian Village** **#** **0026955** **Report Period Beginning:** **July 1, 2004** **Ending:** **June 30, 2005**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	20,183	0	0	0	0	0	0	0	0	0	20,183	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,538)	391	0	0	0	0	0	0	0	0	0	(2,147)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,538)	20,574	0	0	0	0	0	0	0	0	0	18,036	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(13,831)	0	0	0	0	0	0	0	0	0	0	(13,831)	43
44	**TOTAL Special Cost Centers**	(13,831)	0	0	0	0	0	0	0	0	0	0	(13,831)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(111,072)	(33,491)	0	0	0	0	0	0	0	0	0	(144,563)	45

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc	100.00%	$ 11,905	$ 11,905	1
2	V	6	Maintenance				10,139	10,139	2
3	V	17	Administration	280,080			66,904	(213,176)	3
4	V	19	Professional Services				11,419	11,419	4
5	V	21	Clerical				85,522	85,522	5
6	V	22	Employee Benefits				32,465	32,465	6
7	V	24	Travel & Seminar				6,671	6,671	7
8	V	26	Insurance				990	990	8
9	V	30	Depreciation				20,183	20,183	9
10	V	32	Interest				391	391	10
11	V								11
12	V								12
13	V								13
14	Total			$ 280,080			$ 246,589	$ * (33,491)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: ne 30, 2005

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Revenue Bond 2001-Y (92%)	x		Refinance Debt	$13,416.00	10/01/01	$ 2,301,544	$ 2,280,020		0.0700	$ 160,360	1
2	Tax Exempt Bonds		x	Bldg & Equipment	$6,883.33	09/01/91	1,000,000	500,000		0.0600	31,500	2
3	Revenue Bond 1996-A	x		Redeem Debt	$3,867.67	07/01/96	500,000	420,000		0.0700	29,723	3
4	Revolving Loan Fund	x		Roof Work - Bldg	$552.08	11/01/96		38,129		0.0200	826	4
5	Inter-company NP	x		Operations				115,000				5
	Working Capital											
6	CHI Bond Fund	x		Operations	$5,000.00	Various		811,778		0.0850	69,135	6
7	Revenue Bond 1999-A	x		Redeem Debt	$6,739.00	01/01/99		876,200		0.0700	59,755	7
8	Financing Fee Amortiztion										5,544	8
9	TOTAL Facility Related				$36,458.08		$ 3,801,544	$ 5,041,127			$ 356,843	9
	B. Non-Facility Related*											
10	Revenue Bond 2001-Y (8%)	x		Redeem Debt	$1,167.00	10/01/01	198,456	196,646		0.0700	13,831	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related				$1,167.00		$ 198,456	$ 196,646			$ 13,831	14
15	TOTALS (line 9+line14)						$ 4,000,000	$ 5,237,773			$ 370,674	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Washington Christian Village **#** 0026955 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	n/a	2
3. Under or (over) accrual (line 2 minus line 1).	$	#VALUE!	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	#VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	2000	8
	2001	9
	2002	10
	2003	11
	2004	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Washington Christian Village COUNTY Tazwell

FACILITY IDPH LICENSE NUMBER 0026955

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-02-14-300-023	SEC 14 T26N R3W	$ 1,747.46	$
2.	02-02-14-300-021	SEC 14 T26N R3W	$ 13,850.38	$
3.	02-02-14-308-001	SEC 14 T26N R3W	$ 5,986.24	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 21,584.08	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,956 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	38,484	1982	$ 50,000	1
2	Home Office Allocation			8,670	2
3	TOTALS	38,484		$ 58,670	3

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	122		1982		$ 1,203,052	$ 34,373	35	$ 34,373	$	$ 800,035	4
5											5
6											6
7											7
8	Home Office Allocation				62,755	2,023		2,023		31,527	8
	Improvement Type**										
9	Office Door			1982	299	9	35	9		208	9
10	A/C Compressor			1982	1,200		5			1,200	10
11	Improvements			1982	13,562	387	35	387		8,708	11
12	Improvements			1983	34,486	985	35	985		21,916	12
13	Sprinkler System			1983	1,806	72	25	72		1,608	13
14	A/C Condensors			1983	4,775		20			4,775	14
15	Boiler			1983	8,332		20			8,332	15
16	Water Heater			1983	321		15			321	16
17	Sign			1984	2,800		12			2,800	17
18	Door			1984	231	7	20	7		149	18
19	Nurse Call System			1984	2,930		15			2,930	19
20	Alarm System			1984	786	16	20	16		786	20
21	Remodeling			1985	18,956	542	35	542		11,111	21
22	Tub Room			1985	1,230		15			1,230	22
23	Insulation			1985	4,890	245	20	245		4,880	23
24	Light Fixtures			1985	425		10			425	24
25	Ceiling Tile			1985	323	16	20	16		320	25
26	Roof repairs			1985	342,609	9,789	35	9,789		200,674	26
27	Fire door			1986	400	20	20	20		388	27
28	Insulation			1986	4,203	210	20	210		3,920	28
29	Decorations			1988	342		5			342	29
30	Wall coverings			1988	356		5			356	30
31	Improvements			1988	3,706	106	35	106		1,829	31
32	Duct Work			1988	313		10			313	32
33	Painting(Remodeling)			1988	886		5			886	33
34	Wallpaper			1988	910		5			910	34
35	Nurse Call System			1989	8,534		15			8,534	35
36	22 Overbed lights			1989	1,579		10			1,579	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Bath station	1989	$ 558	$	15	$	$	$ 558	37
38	Floor coverings	1990	1,765		5			1,765	38
39	Relay Stone and Tuckwork	1991	2,395	120	20	120		1,710	39
40	Water Heater	1991	1,223		10			1,223	40
41	Gutter & Soffit	1992	9,161	611	15	611		7,943	41
42	Water Heater	1993	1,134		10			1,134	42
43	Boiler	1993	11,405	760	15	760		8,803	43
44	Fire System-Horn/Strobe	1994	1,560		10			1,560	44
45	Water Heater	1994	890		10			890	45
46	Main/Store Room Doors	1994	1,730	29	10	29		1,730	46
47	Electrical Outlets	1994	813	17	10	17		813	47
48	Blank								48
49	Doors	1995	3,368	195	10	195		3,368	49
50	Cabinets SFF Dining	1995	2,189	146	15	146		1,484	50
51	Hot H20 Lines/Rerout	1995	7,345		5			7,345	51
52	Rubber Adhered Roof	1996	62,678	3,134	20	3,134		29,512	52
53	BTC 200 Water Heater	1996	2,384	238	10	238		2,241	53
54	Kitchen Door	1996	622	62	10	62		579	54
55	Exhaust Fan/Light	1996	918	92	10	92		836	55
56	Add 4 baseboard heaters	1996	1,100	110	10	110		963	56
57	Wallpaper	1996	2,417		5			2,417	57
58	Remodel foyer area	1996	17,101	1,710	10	1,710		14,677	58
59	Carpeting - Front Entry	1997	974		5			974	59
60	Roof Work - North Wing	1997	32,480	2,165	15	2,165		16,598	60
61	IDPH Construction Project fee	1997	910	91	10	91		546	61
62	Wallpaper SW alcove	1998	1,030		5			1,030	62
63	Replace cove base	1999	2,009	201	10	201		1,390	63
64	100 gal. Gas water heater	1999	2,358	236	10	236		1,613	64
65	Kitchen fire suppression system	1999	1,307	131	10	131		862	65
66	Wallpaper office conference room	1999	2,148		5			2,148	66
67	Condensing unit	1999	875	88	10	88		535	67
68	Wallpaper office alcove	1999	1,894		5			1,894	68
69	Carpeting offices	1999	3,510		5			3,510	69
70	TOTAL (lines 4 thru 69)		$ 1,909,248	$ 58,936		$ 58,936	$	$ 1,245,643	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,909,248	$ 58,936		$ 58,936	$	$ 1,245,643	1
2	Chaplain's Office A/C Unit	2000	875	88	10	88		484	2
3	Smoke Detectors (3)	2000	544	54	10	54		320	3
4	Boiler	2000	5,250	263	20	263		1,337	4
5	Automatic Opener Front Doors	2000	5,204	520	10	520		2,427	5
6	Airphone Emergency Phone System	2001	2,005	201	10	201		888	6
7	Remodeling South Wing	2001	47,029	3,135	15	3,135		13,324	7
8	Carpet E/W Corridors & Volunteer Ofc	10/1/2001	2,419	484	5	484		1,815	8
9	Remodeling South Wing	9/1/2001	1,755	117	15	117		449	9
10	Upgrades to Boiler System	11/1/2001	19,857	1,986	10	1,986		7,282	10
11	(3) Steel Doors	12/24/2001	1,371	137	10	137		491	11
12	Modular Nurses Station	5/24/2002	4,744	474	10	474		1,501	12
13	Opto 22 - Heating/AC Control System	1/8/2002	15,227	761	20	761		2,664	13
14	Architects Fees/Remodeling of Building	6/1/2002	11,383	759	15	759		2,340	14
15	Remodeling	4/30/2002	93,076	6,205	15	6,205		20,166	15
16	Remodel Front Entrance	4/24/2002	840	56	15	56		182	16
17	Remodel North Corridor/Wall Coverings	5/1/2002	66,545	13,309	5	13,309		42,145	17
18	Remodel North Corridor/Carpet	4/30/2002	27,270	5,454	5	5,454		17,726	18
19	Remodel North Corridor/Cove Base Hand Rail	4/30/2002	20,507	1,367	15	1,367		4,443	19
20	Replace A/C in Lobby	4/25/2002	2,276	228	10	228		741	20
21	Carpet/New Offices Near Lunch Room	5/1/2002	560	112	5	112		355	21
22	Corridor Door	4/30/2002	743	74	10	74		241	22
23	Remodel New Offices Near Lunch Room	5/1/2002	1,319	132	10	132		418	23
24	Carpet/Kitchen, Storage Rm, Back Ofc & H	6/21/2002	6,262	1,252	5	1,252		3,860	24
25	100 Gallon AO Smith Water Heater	7/17/2002	3,600	360	10	360		1,080	25
26	Remodeling - Offices	3/1/2003	8,522	852	10	852		1,988	26
27	Remodel Employee Break Room	3/1/2003	2,118	424	5	424		976	27
28	Architects Fees/Building Front	3/1/2003	319	21	15	21		49	28
29	Remodel Front Entrance	8/8/2003	34,300	2,287	15	2,287		4,383	29
30	Tile Floors-Rms 154 & 174 Central Hall etc	9/13/2003	882	176	5	176		323	30
31	Repipe Boiler System	10/8/2003	2,581	258	10	258		452	31
32	Replace Tubes & Tube Sheets/Boiler	11/6/2003	6,950	1,390	5	1,390		2,317	32
33	Roof Repairs	11/13/2003	2,758	552	5	552		920	33
34	TOTAL (lines 1 thru 33)		$ 2,308,339	$ 102,424		$ 102,424	$	$ 1,383,730	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,308,339	$ 102,424		$ 102,424	$	$ 1,383,730	1
2	Fabricate/Install Piping - O2 Room	1/22/2004	580	116	5	116		174	2
3	(2) Auto Door Closers	1/29/2004	527	105	5	105		158	3
4	Move/Add Smoke Detectors	2/17/2004	3,503	350	10	350		496	4
5	Project Review Fee	2/29/2004	2,400		10				5
6	Remodel SW Alcove	5/17/2004	909	91	10	91		106	6
7	A/C Compressor - Activity Dept	6/11/2004	1,462	487	3	487		528	7
8	Commercial Disposal	7/19/2004	1,105	221	5	221		221	8
9	Engineering Costs - Sprinkler System	8/12/2004	11,556	1,060	10	1,060		1,060	9
10	Convert Activity Space to PT	12/31/2004	11,042	644	10	644		644	10
11	Installation of New Sprinkler System	2/1/2005	115,822	4,826	10	4,826		4,826	11
12	Redo South Desk Area (State Regs)	4/1/2005	2,231	56	10	56		56	12
13	Remodel Southeast Shower Room	2/4/2005	3,079		5				13
14	Fire Doors in Center Hall	3/22/2005	2,054	85	10	85		85	14
15	Install Fire Doors/Central Hall & Linen Closet	3/26/2005	3,600	120	10	120		120	15
16	West Wing Closet Door w/installation	5/24/2005	1,655	55	5	55		55	16
17	Remodel SW Hall/Lobby	6/1/2005	91,120		15				17
18	Outside shelter	2/20/1996	5,349	535	10	535		5,038	18
19	16 x 18 shed	11/7/1997	2,520	252	10	252		1,932	19
20	Fully depreciated land improvements	4/1/1982	43,675		15			43,675	20
21	Sewer	2/26/1988	987	49	20	49		853	21
22	Blacktop	8/25/1988	7,275		15			7,275	22
23	Resurface parking	6/30/1993	10,785		10			10,785	23
24	Sidewalk, west	10/22/1996	950	95	10	95		831	24
25	Landscaping front	5/6/2002	11,053	1,105	10	1,105		4,400	25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,643,578	$ 112,676		$ 112,676	$	$ 1,467,048	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 307,992	$ 36,110	$ 36,110	$	Various	$ 170,212	71
72	Current Year Purchases	56,891	4,382	4,382		Various	4,382	72
73	Fully Depreciated Assets	235,333				Various	235,333	73
74	Home Office Allocation	111,073	15,340	15,340			59,176	74
75	TOTALS	$ 711,289	$ 55,832	$ 55,832	$		$ 469,103	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1995 Ford Bus	1995	$ 44,381	$	$	$	8	$ 44,381	76
77										77
78										78
79	Home Office Allocations			13,041	2,820	2,820			4,961	79
80	TOTALS			$ 57,422	$ 2,820	$ 2,820	$		$ 49,342	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,470,959	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 171,328	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 171,328	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,985,493	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 120,656	$	$	86
87	Land Improvements	8,903	473	7,221	87
88	Buildings & Equipment	673,547	25,194	436,060	88
89					89
90					90
91	TOTALS	$ 803,106	$ 25,667	$ 443,281	91

G. Construction-in-Progress

	Description	Cost	
92	CIPB	$ 27,399	92
93			93
94			94
95		$ 27,399	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This workpaper is not applicable.
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ ____ Description: ____
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Washington Christian Village **#** 0026955 **Report Period Beginning:** July 1, 2004 **Ending:** June 30, 2005

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** June 30, 2005 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 108,177	$	1
2	Cash-Patient Deposits	10,431		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 31,656)	734,111		3
4	Supply Inventory (priced at FIFO)	23,803		4
5	Short-Term Investments	4,126		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	4,829		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Acc Int Rec	645		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 886,122	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	170,656		13
14	Buildings, at Historical Cost	3,157,905		14
15	Leasehold Improvements, at Historical Cost	83,628		15
16	Equipment, at Historical Cost	666,331		16
17	Accumulated Depreciation (book methods)	(2,333,110)		17
18	Deferred Charges	7,194		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	133,230		21
22	Other Long-Term Assets (spe CIP	27,399		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,913,233	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,799,355	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 297,619	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	10,431		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	168,039		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,584		32
33	Accrued Interest Payable	2,500		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Revolving Bond Fund	38,129		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 538,302	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	115,000		39
40	Mortgage Payable			40
41	Bonds Payable	5,084,644		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Apt Income	72,402		43
44	Apt & Cong Life Rights	78,399		44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,350,445	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,888,747	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,089,392)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,799,355	$	48

***(See instructions.)**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,397,308)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,397,308)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(507,084)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (507,084)	17
	B. Transfers (Itemize):		
18	**Transfer in from Affiliate**	815,000	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 815,000	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,089,392)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,902,558	1
2	Discounts and Allowances for all Levels	(2,369,224)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,533,334	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	538,550	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 538,550	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	24,381	13
14	Non-Patient Meals	2,261	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,083	19
20	Radiology and X-Ray	13,610	20
21	Other Medical Services	4,324	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 55,659	23
	D. Non-Operating Revenue		
24	Contributions	32,278	24
25	Interest and Other Investment Income***	5,310	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 37,588	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized Holding G(L)/Disposals G(L)	796	28
28a	Residential/Congregate	188,179	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 188,975	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,354,106	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	917,489	31
32	Health Care	2,855,434	32
33	General Administration	1,341,148	33
	B. Capital Expense		
34	Ownership	509,155	34
	C. Ancillary Expense		
35	Special Cost Centers	171,169	35
36	Provider Participation Fee	66,795	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,861,190	40
41	**Income before Income Taxes (line 30 minus line 40)****	(507,084)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (507,084)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,783	1,877	$ 52,572	$ 28.01	1
2	Assistant Director of Nursing	1,790	1,884	43,586	23.13	2
3	Registered Nurses	12,108	12,777	313,191	24.51	3
4	Licensed Practical Nurses	24,282	26,032	531,975	20.44	4
5	CNAs & Orderlies	87,232	90,667	1,143,144	12.61	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,042	2,112	24,853	11.77	8
9	Activity Director	1,082	1,098	17,163	15.63	9
10	Activity Assistants	1,871	1,899	20,450	10.77	10
11	Social Service Workers	9,043	9,176	110,722	12.07	11
12	Dietician					12
13	Food Service Supervisor	1,170	1,246	18,383	14.75	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,925	20,696	190,686	9.21	15
16	Dishwashers					16
17	Maintenance Workers	5,392	5,491	70,850	12.90	17
18	Housekeepers	18,050	18,623	172,613	9.27	18
19	Laundry					19
20	Administrator	2,122	2,159	89,912	41.65	20
21	Assistant Administrator					21
22	Other Administrative	1,789	1,822	49,993	27.44	22
23	Office Manager	1,894	1,928	39,385	20.43	23
24	Clerical	2,877	2,929	29,753	10.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	1,457	1,545	22,377	14.48	33
34	TOTAL (lines 1 - 33)	195,909	203,961	$ 2,941,608 *	$ 14.42	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	271	$ 11,770	1.3	35
36	Medical Director	72	7,200	9.3	36
37	Medical Records Consultant	60	4,320	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	115	3,685	10.3	39
40	Physical Therapy Consultant	1,372	68,546	10A.3	40
41	Occupational Therapy Consultant	1,315	66,172	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	277	13,850	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	53	3,049	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,535	$ 178,592		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jodi Nylin	Administrator	0	$ 13,566
Larry Weappa	Administrator	0	76,346
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,912

B. Administrative - Other

Description	Amount
Management fee	$ 280,080
Other administrative expenses	8,972
TOTAL (agree to Schedule V, line 17, col. 3)	$ 289,052
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Davis & Campbell	Legal	$ 4,749
RCS Management	Consulting	276
Kreig DeVault	Legal	1,195
Van Ostrand	Legal	7,648
American Recruiters	Employment	18,480
Jeff Pacheco	Consulting	338
Gaius Nelson Architect	Architect	33
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 32,719

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 93,045
Unemployment Compensation Insurance	16,892
FICA Taxes	214,944
Employee Health Insurance	193,540
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
WC Medical Expense	39
Employee Expense	10,641
Employee Physicals	4,325
Employee Uniforms	212
Home Office Allocation	32,465
TOTAL (agree to Schedule V, line 22, col.8)	$ 566,103

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,377
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses	1,009
Dues	11,051
Subscriptions	2,593
LEAP Program	1,000
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,030

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	11,634
Miscellaneous	1,834
Seminar Expense	4,094
Home Office Allocation	6,671
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,233

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 2005

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Washington Christian Village # 0026955 Report Period Beginning: July 1, 2004 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Serv. Net: $6,426 NAGNA: $1,400**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **n/a**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **16,785** Line **3.10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **66,795**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,261**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **It will be provided upon completion.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Washington Christian Village
Allocation on Benefits 6/30/2005 kdb 10/21/04

Payroll Tax	Unemploy Contrib	Worker's Comp	Health Ins	W C Medical Exp	Employee Uniform Allow	Employee Expense	Employee Physicals		
11,506.73	16,892.00	93,045.00	4,500.00	39.00	212.00	10,118.90		136,313.63	
3,503.48			820.00			330.00	4,325.00	8,978.48	
4,658.03			8,160.00			191.79		13,009.82	
15,734.77			12,680.00					28,414.77	
11,933.33			22,960.00					34,893.33	
1,660.24									
155,536.44			121,500.00					277,036.44	
10,410.99			22,920.00					33,330.99	531,977.46
214,944.01	16,892.00	93,045.00	193,540.00	39	212.00	10,640.69	4,325.00	533,637.70	

Line 3.22.3 533,637.70

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